MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Doctors Hospital of Dallas P.O. Box 809053 Dallas, TX 75380-9053	MDR Tracking No.: M4-03-4660-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas I.S.D. Box 42 c/o Harris & Harris P.O. Box 462663 Austin, TX 78716	Date of Injury: Employer's Name: Dallas ISD Insurance Carrier's No.: 00000266

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
05/15/02	**05/16/02**	**Outpatient Hospitalization**	**$12,769.24**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position summary or additional information. The Requestor's Rationale on the Table of Disputed services states that 1st Health contract with this facility states that reimbursement will be 78% of the total outpatient charges.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

On April 10, 2003 the Requestor was sent a letter requesting additional information in accordance with Rule 133.307(g)(3)(B). The requesting party did not submit any additional information. The requestor states on the Table of Disputed Services that the contract between the health care provider and First Health indicates payment should be rendered at 78% of the total cost of the admission. Neither party submitted a copy of the contract; therefore, MDR cannot make a determination on correct payment per the contract and declines to issue an order.

PART VII: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	June 9, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____